Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 25, 2019

Mr. Dan Strittmater, Vice President of Operations/ Administrator
Parmly On The Lake LLC
28210 Old Towne Road
Chisago City, MN 55013

Subject: Parmly On The Lake LLC - IDR
CMS Certification Number (CCN) 245328
Project # S5328026

Dear Mr. Strittmater:

This is in response to the letter of September 13, 2018, in regard to the facility's request of an informal dispute resolution (IDR) for the federal deficiency at tag F678 issued pursuant to the survey event, completed on 8/16/18.

The information presented with your letter, the CMS 2567 dated and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F678 (J) 42 CFR §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

Summary of the facility's reason for IDR of this tag:
The facility maintains the nurse expressed valid reasoning for not initiating CPR based on obvious clinical signs of death noted at the time of the incident.

Summary of facts:
R82's admission diagnoses included chronic respiratory failure with hypoxia, unspecified diastolic congestive heart failure, atrial fibrillation hypertension, sleep apnea, and dependence on supplemental oxygen. R82's Provider Orders for Life Sustaining Treatment (POLST) directed staff to attempt cardiopulmonary resuscitation if patient had no pulse and was found not breathing. The POLST was signed by R82's spouse on 6/20/18, and by the advance practice nurse practitioner on 6/21/18. In addition, the progress notes from 6/21/18, noted R82's plan was for short term stay and to return home after OT and PT were completed. A progress note dated 6/29/18, indicated R82 wished to transfer to another facility to be closer to home, and the facility had faxed a referral.

Facility documentation revealed on 7/1/18, at 3:00 a.m. R82 was calm and oxygen sats had come up to 90% with (the oxygen) 5 LPM. At 4:30 a.m. Nursing Assistant (NA) looked into R82's room and R82 did

not appear restless. When the same NA went into R82's room again at 5:00 a.m. R82 appeared not breathing, oxygen mask was lying on floor by foot of bed, and covers were lying on floor next to bed. NA failed to initiate CPR. Ten minutes later, at 5:10 a.m. nurse assessed R82, who had no respirations, no heart rate, was cool to the touch, and limbs were starting to get stiff. Mottling was significant on back of legs, arms, hands and back. Nurse checked R82's code status which was CPR with selective treatment, however No CPR was initiated.

Summary of findings:
Regulatory requirements indicate personnel are to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. R82 had a current POLST to attempt resuscitation/ CPR in case patient had no pulse and was not breathing. When found unresponsive on 7/1/18, at 5:00 a.m. staff did not initiate CPR, as directed by the POLST, did not call 911 (or EMS), and did not call the Physician.

This is a valid deficiency at this tag and at the correct scope and severity of J.

This concludes the Minnesota Department of Health informal dispute resolution process.

Please note it is your responsibility to share the information contained in this letter and the results of this review with the President of your facility's Governing Body.

Sincerely,

Eva Loch, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-3792 Fax: 651-215-9697

cc: Office of Ombudsman for Long-Term Care
Brenda Fischer, Assistant Program Manager
Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: CS2O
Facility ID: 00065

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245328**
2. STATE VENDOR OR MEDICAID NO. (L2) **427240400**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARMLY ON THE LAKE LLC**
(L4) **28210 OLD TOWNE ROAD**
(L5) **CHISAGO CITY, MN** (L6) **55013**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **12/29/2017**
6. DATE OF SURVEY **09/27/2018** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **101** (L18)
13. Total Certified Beds **101** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE - NE II 10/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/16/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
October 16, 2018

Administrator
Parmly On The Lake LLC
28210 Old Towne Road
Chisago City, MN 55013

RE: Project Number S5328026, H532804 and 5328023

Dear Administrator:

On September 4, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 9, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective November 4, 2018.

- Civil money penalty. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on August 16, 2018 that included an investigation of complaint number H532804 and 5328023. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On September 27, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 10, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on August 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 8, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on August 16, 2018, as of October 8, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 8, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective be discontinued as of October 8, 2018. (42 CFR 488.417 (b))

- Civil money penalty. (42 CFR 488.430 through 488.444)

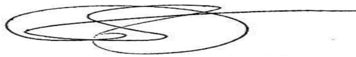
However, as we notified you in our letter of September 4, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 16, 2018.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered CMS Certification Number (CCN): 245328

October 16, 2018

Administrator
Parmly On The Lake LLC
28210 Old Towne Road
Chisago City, MN 55013

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 8, 2018 the above facility is certified for:

101 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 101 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

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2.STATE VENDOR OR MEDICAID NO.
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5. Validation
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7. On-Site Visit
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8. Full Survey After Complaint

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(L9) **12/29/2017**

6. DATE OF SURVEY **08/16/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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Program Requirements
Compliance Based On:
____1. Acceptable POC

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And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

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(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date:
Karen Aldinger, HFE NE II 09/17/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 10/15/2018 (L20)

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____ 2. Facility is not Eligible
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3. Both of the Above :

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(L24)

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26. TERMINATION ACTION: (L30)

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01-Merger, Closure
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04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

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(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
September 4, 2018

Administrator
Parmly On The Lake LLC
28210 Old Towne Road
Chisago City, MN 55013

RE: Project Number S5328026, H532804 and 5328023

Dear Administrator:

On August 16, 2018, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 16, 2018 extended survey the Minnesota Department of Health completed an investigation of complaint number 5328023.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the August 16, 2018 extended survey the Minnesota Department of Health completed an investigation of complaint number H532804 that was found to be unsubstantiated.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care means one or more deficiencies related to participation requirements under 42 CFR 483.10, Residents Rights, 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread

actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm, 42 CFR 483.40 Behavioral Health Services, 42 CFR 483.45 Pharmacy Services, 42 CFR 483.70 Administration, or 42 CFR 483.80 Infection control;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 15, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective September 9, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective November 4, 2018.

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Parmly On The Lake LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 16, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 4, 2018, the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 16, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

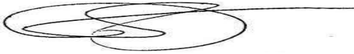
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

A recertification survey along with an extended survey was conducted August 13, 14, 15, and 16, 2018 and complaint investigations were also completed at the time of the standard survey. An investigation of complaint #H5328024 was completed and was found to be unsubstantiated. An investigation of complaint #5328023 was also completed and was substantiated at F678 at an immediate jeopardy level.

An immediate jeopardy was cited at F678. The immediate jeopardy began on 7/1/18, at 5:00 a.m. when CPR was not initiated for R82 when he was found unresponsive and without pulse or respirations, and staff did not administer CPR according to his advanced directives. This had the potential to affect 22 other residents in the facility who had physician's orders for CPR in the event of a cardiac arrest. The administrator and director of nursing (DON) were informed of the immediate jeopardy on 8/15/18, at 5:25 p.m. The immediate jeopardy was removed on 8/16/18, at 2:50 p.m. but noncompliance remained at the lower scope and severity of a G, isolated actual harm that is not immediate jeopardy.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.

Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 regulations has been attained in accordance with your verification.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.	F 578		9/25/18

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F 578	Continued From page 2 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident's resuscitation status order matched the resident's stated request of Do Not Resuscitate (DNR) for 1 of 1 residents (R232) reviewed for advance directives. Findings include: R232's Diagnosis Report dated 8/13/18, indicated diagnoses that included encephalopathy (diseases of the brain), and dementia. R232's admission Minimum Data Set (MDS) dated 7/17/18, indicated R232 was cognitively intact, was able to make himself understood, and usually understood others. The MDS also indicated it was very important to R232 to have family or a close friend involved in discussions about his care. On 8/13/18, at 6:49 p.m. R232's Physican's Orders for Life Sustaining Treatment (POLST) was reviewed and indicated "Do Not Attempt Resuscitation" (DNR). R232 signed and dated the POLST on 8/11/18. The POLST was signed and dated by a nurse practioner on 8/12/18. R232's Initial/Comprehensive care plan dated 8/11/18, indicated R232's current code status was DNR/Do Not Intubate (DNI).	F 578	All residents have potential of being affected if their Advance Directive orders do not match. R232□s POLST and orders were reviewed for rights to refuse/discontinue treatment, POLST, Orders and Plan of care and interventions have been updated and reviewed to reflect resident□s DNR resuscitation choice. Resident discharged from facility on 8/30/18. All current residents□ POLSTs and Orders have been reviewed and updated for Advanced Directive treatment options. Residents□ orders and plan of care have been updated. The clinical process of ensuring resident□s Advance Directive options are consistent and updated from admission through discharge has been put in place. All IDT members who participating in this process including the HICs, Providers and Nursing have been educated on this process. Audits of all residents for resident Advance Directives selections, POLST and orders will be completed weekly x 4 weeks. Audits will be reviewed by QAPI to ensure completion and/or continuation of monitoring process. Director of Nursing or designee will be responsible party	

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F 578	Continued From page 3	F 578	Completion Date: September 25th, 2018	

On 8/13/18, at 6:49 p.m. R232's Admission Record indicated Cardiopulmonary Resuscitation (CPR) and the undated group sheet also indicated R232 was CPR.

R232's Order Summary Report dated 8/13/18, indicated an 8/11/18, order of CPR (full code).

On 8/16/18, at 10:06 a.m. R232 stated he switched from CPR to DNR on the advice of his brother. R232 stated his brother had told him that CPR on older people doesn't work out that well, and he wouldn't have it done. R232 stated he gave it some thought, and as his brother has a lot more information than he does, he decided to be DNR. R232 stated, "Being an invalid is less desirable than dying."

On 8/13/18, at 7:19 p.m. licensed practical nurse (LPN)-G stated she enters code status right into resident charts. LPN-G stated nurses do admissions on the weekends. LPN-G confirmed that R232's code status in the medical record, his order summary report, and the group sheet did not match his wishes as indicated on the signed POLST.

On 8/13/18, at 7:30 p.m. the director of nursing (DON) confirmed R232's POLST indicated DNR, and this did not match the physician order, or other parts of his medical record.

The facility's Cardiopulmonary Resuscitation Protocol dated 5/15, indicated individual medical emergency response plans are developed for each resident based upon their individualized assessment, needs, and advance directives. The protocol further indicated the nurse and/or clinical team would guide care according to the resident's

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F 578	Continued From page 4 identified preferences indicated on the physicians orders and within the plan of care.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F 580		9/25/18

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F 580	Continued From page 5 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident's medical provider was notified of a change of condition for 1 of 1 residents (R82) reviewed for notification of change. Findings include: R82's Admission Record printed 8/15/18, indicated diagnoses that included chronic respiratory failure with hypoxia, unspecified diastolic congestive heart failure (CHF), atrial fibrillation (irregular heart beat), hypertension, sleep apnea, and dependence on supplemental oxygen. R82's 5 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 6/27/18, indicated he was cognitively intact, required extensive assistance with all activities of daily living (ADLs) except walking in his room and on the unit. The MDS further indicated R82 had anxiety and respiratory failure, and used oxygen	F 580	All residents have potential of being affected if MD not notified with changes in condition. R82 is deceased. All current resident□s status continues to be monitored daily with routine cares and changes reported to MD as needed. Nursing staff have been re-educated on the MD notification process for all residents□ change in status. Resident change in condition with appropriate MD notification will be audited daily x 4 weeks in IDT meetings, with daily Nursing rounds and as reported by other disciplines. Audits will be reviewed by QAPI to ensure completion and/or continuation of monitoring process. Director of Nursing or designee will be responsible party Completion Date: September 25th, 2018	

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F 580		F 580		

Continued From page 6
therapy.

R82's Order Summary Report printed on 8/15/18, indicated orders that included a 6/22/18, order for use of a continuous positive airway pressure (CPAP) machine (used to treat sleep apnea) every evening and night shift for sleep apnea, a 6/20/18, order for oxygen by nasal cannula at 5 liters per minutes (LPM) to keep oxygen saturations at greater than 88% to 94%. The oxygen order indicated baseline supplemental oxygen at 2 LPM at rest, with increase to 4-6 L with activity. R82's order summary report also included a 6/20/18, order for CPR with selective treatment.

R82's Initial Comprehensive care plan dated 6/20/18, indicated the resident would have no signs or symptoms of respiratory distress, and would maintain patent airway through the review period. Interventions included to observe for signs and symptoms of respiratory distress, oxygen as ordered, CPAP machine at night as ordered, nebulizer/inhaler medications per order, and the head of bed elevated.

A 6/21/18, progress note indicated an initial care conference was held on 6/21/18, and R82 planned short term stay with plans to return home after physical therapy (PT) and occupational therapy (OT) were complete.

On 6/29/18, at 2:14 p.m. a progress note indicated R82 wished to transfer to another facility to be closer to home, and a referral was faxed.

On 6/29/18, at 10:28 p.m. a progress note indicated R82 had 2 episodes of emesis, had stated he didn't feel well, and had thrown up in his

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F 580	Continued From page 7 sleep. On 6/29/18, at 10:35 p.m. a progress note dated indicated R82's CPAP machine was not utilized due to the 2 episodes of emesis. On 7/1/18, at 2:52 a.m. a progress note indicated R82 would not wear the CPAP mask. On 7/1/18, at 5:51 a.m. a progress note indicated, "At about 0200 [2:00 a.m.] this writer and NAR [nursing assistant registered] went in to patients room to do complete bed change d/t [due to] large incontinent void. Patient was having significant tachypnea, was anxious, and accelerated heart rate. Oxygen sats checked and were at 72% with NC [nasal cannula] in place. Oxygen was at 5 LPM [liters per minute]. This writer switched NC to oxygen mask d/t patient breathing heavily through mouth. This writer sat with patient encouraging slow breathing and to breath in through nose and out through mouth. About 0230 patient was starting to calm down and oxygen sats were at 83%. Patient was able to be roused and was responding appropriately. Patient continued having brief episodes of tachypnea, and this writer talked patient through episodes. At 0300 patient was calmed and oxygen sats had come up to 90% at the 5 LPM. When this writer left room, patient was calm and breathing was stable. NAR had looked into patients room around 0430 and patient did not appear restless. When NAR went into patients room again at 0500, patient appeared to not be breathing, oxygen mask was lying on floor by foot of bed, and covers were lying on floor next to bed. NAR alerted this writer about patient. This writer went into room at 0510 and patient had no respirations, no heart rate, was cool to the touch,	F 580		

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F 580	Continued From page 8	F 580		

and limbs were starting to get stiff. Mottling was significant on back of legs, arms, hands, and back. This writer checked patients code status which was CPR with selective treatment. Based on findings/condition of patient, CPR was not performed."

On 8/15/18, at 11:23 a.m. the director of nursing (DON) stated she had not been working at the facility at the time R82 had lived there.

On 8/15/18, at 11:20 a.m. the registered nurse consultant (RNC) stated she felt the LPN should have notified the physician when R82's oxygen saturation dropped to 72%.

On 8/15/18, at 2:14 p.m. the geriatric nurse practitioner (GNP) stated an on-call provider should have been notified of R82's declining condition.

The facility Change of Condition/Special Needs Charting policy revised May, 2011, directed staff should report to the physician immediately if the resident experiences vital signs that vary significantly for the residents normal limits or any significant change in condition as determined by a licensed nurse. The policy further directed staff should notify family or significant other when there is a change in status of a resident.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		9/25/18

§483.10(h) Privacy and Confidentiality.
The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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F 583	Continued From page 9 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to discuss personal medical information in a private area for 1 of 1 residents (R72) who was told her weight in the dining room area where eight other residents were present. Findings include:	F 583	All residents have the potential of being affected if their privacy is not upheld. R72□s cares and sharing of Private information was immediately reviewed during survey process and resident□s privacy is being upheld. All other residents will continue to be provided with privacy for all cares and information pertaining to their cares.	

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F 583	Continued From page 10 R72's Admission Record printed on 8/16/18, indicated diagnoses that included nontraumatic hematoma of soft tissue, muscle weakness, and hypertension. R72's admission Minimum Data Set (MDS) dated 7/30/18, indicated R72 was cognitively intact, had no behaviors or refusals of care, used a hearing aide and had minimal difficulty hearing. The MDS further indicated R72 was able to be understood, usually understood others, and it was very important to R72 to be able to use a phone in private. R72's Weights and Vitals Summary dated 8/16/18, indicated a weight for 8/14/18, of 175 pounds. On 8/14/18, at 8:24 a.m. nursing assistant (NA)-F approached R72 asked her to get on the scale, which was in the hallway portion of the dining room. R72 got on the scale and NA-F loudly stated R72's weight of "174 pounds." NA-F could be heard throughout the dining room and into the nursing station on the far side of the dining room. There were 8 residents in the dining room. On 8/14/18, at 8:48 a.m. R72 stated she had heard NA-F loudly say her weight, and she shouldn't do that. R72 stated, "That is a private matter." On 8/14/18, at 9:05 a.m. NA-F confirmed she weighed R72 in the dining room area, and said her weight loudly. NA-F stated she usually whispered weights. On 8/16/18, at 10:21 a.m. licensed practical nurse (LPN)-K stated all residents get weighed on	F 583	Scales for weight collection will be placed in private and secure areas to enhance residents privacy. Staff have been re-educated on HIPPA and ensuring resident s privacy is upheld at all times. Audits of resident privacy will be completed weekly for 10 residents with management rounding x 4 weeks then on-going and as needed. Administrator/DON or designee will be responsible party QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process Completion Date: September 25th, 2018	

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F 583	Continued From page 11 Wednesdays, but some resident have orders for more frequent weights. LPN-K stated many of the residents on their unit are alert and oriented and want to know their weights, as they keep track as part of monitoring their health. LPN-K stated weights are private information, and should not be stated in the dining room. On 8/16/18, the director of nursing (DON) stated if scales were mobile, then residents should be weighed in their rooms or in a shower room. The DON stated weights should not be stated in a dining room, that is private information, and a dignity issue. A policy on personal privacy in conversations was requested but not received from the facility The facility's employee handout titled Health Insurance Portability and Accountability Act, dated 7/16, did not address sharing private information in order to not be overhead.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		9/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 12	F 585		

facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 585	Continued From page 13 example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585		

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F 585	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a family member's concerns were acted upon and followed up on for 1 of 1 residents (R64) reviewed for grievances. Findings include: R64's Admission Record printed 8/16/18, included diagnoses of vascular dementia with behavioral disturbances, delusional disorder, and blindness. R63's annual Minimum Data Set (MDS) dated 8/6/18, indicated R64 had short and long term memory loss, and severely impaired decision making skills. The MDS also indicated R64 required extensive assistance with all activities of daily living (ADL). On 8/15/18, at 12:46 p.m. R64's family member (FM)-A was interviewed. FM-A stated she had many concerns about the care R64 was receiving. FM-A stated she brought up concerns to the facility nearly every day, and felt the concerns went unresolved. FM-A voiced the following concerns: R64 was on thickened liquids, and staff were not supposed to use straws to give R64 fluids, yet R64 frequently had glasses with straws at the bedside. R64 needed to be fed, and R64 was supposed to be participating in eating and had adaptive utensils so R64 could participate. R64 did not always have adaptive utensils available. FM-A stated this included last night at supper.	F 585	All residents have potential of being affected if their grievances and concerns are not appropriately addressed. R64□s Plan of care for all concerns identified during survey have been reviewed and updated to meet resident□s individualized needs and interventions. R64's family member was updated. The facility grievance process has been reviewed and updated to ensure all residents, staff and family members understand the grievance process. The facility grievance process was added to the admission packet for all new admissions. The Social Services Director met with the Resident Council on September 5, 2018 to explained the grievance procedure and to answer questions. A sign will be posted for 4 weeks at the main entrance informing families and visitors of the facility grievance policy and procedure. The entire IDT team including frontline staff has been re-educated on the process of bringing grievances/concerns to a resolution. Audits of all residents for concerns/grievances will be completed with weekly management rounds x 4 weeks; then with routine care conferences and as needed. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process. Administrator or designee will be responsible party	

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 585	Continued From page 15	F 585	Completion Date: September 25th, 2018	

FM-A stated the facility was short staffed, and FM-A was often the one who had to transfer, feed and put R64 to bed because no staff was available. FM-A visited R64 every day.

R64 was supposed to have an adaptive call light. R64 had resided at the facility for almost two years, and never had an adaptive call light. FM-A asked maintenance about getting R64 the adaptive call light, and was told the corporation was really slow. FM-A stated the call light concern was mentioned to the administrator, and FM-A was told he had just signed the requisition.

FM-A stated R64 was to get a bath two times a week, but R64 did not always get the second bath in the evenings. FM-A stated she was given several excuses such as the tub was broken, and the staff cannot do a bath after 6:00 p.m. because the kitchen used all the hot water. R64's bath was moved from the evening to late afternoon, so now staff were telling her the tub did not work.

On 8/16/18, at 10:06 a.m. registered nurse (RN)-B stated FM-A had brought concerns to her. RN-B
stated she had not filled out a grievance form for FM-A, and further stated the facility had a new process they were just learning about it. RN-B stated she was aware of FM-A's concerns regarding the call light and the straws.

On 8/16/18, at 2:38 p.m. the social worker (SW)-A stated she had not heard any complaints or concerns from FM-A, or from staff. SW-A stated during R64's care conference FM-A had mentioned staff had forgot R64's specialized cup, and other small stuff, but nothing regarding R64's

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 585	Continued From page 16 direct care. SW-A further stated they reassure FM-A. SW-A stated she had not kept a log or a file on FM-A's concerns. SW-A stated she was aware of the process on how to file a grievance. On 8/16/18, at 3:30 p.m. the corporate consultant nurse stated staff were expected to file a grievance with any resident or family concerns. The facility's Complaint and Grievance procedure dated 2/18, directed a grievance form should be completed when a verbal complaint had been voiced. This included when a grievance had been right away to show documentation that it was addressed and resolved to the satisfaction of the person voicing the concern.	F 585		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		9/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 623	Continued From page 17	F 623		

(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 623	Continued From page 18 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure written notification of hospital transfers was provided to the	F 623	All residents have the potential to be affected if the Ombudsman is not notified of residents transferred to hospital and	

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 623	Continued From page 19 ombudsman for 15 of 15 residents (R53, R82, R83, R42, R75, R27, R50, R182, R183, R184, R185, R186, R187, R188, and R189) who had been transferred to the hospital since 5/1/18. Findings include: R53's Admission Record printed 8/16/18, indicated R53 had been admitted to the facility on 7/9/18, and diagnoses included heart failure, dementia, and seizures. R53's hospital Discharge Summary dated 8/13/18, indicated R53 had been admitted to the hospital on 8/11/18, and was discharge back to the facility on 8/13/18. R53's medical record lacked documentation regarding notification to the ombudsman regarding R53's transfer to the hospital. On 8/15/18, at 9:40 a.m. registered nurse (RN)-B stated the social worker would notify the ombudsman of hospital transfers or admissions. On 8/16/18, at 9:34 a.m. social services director (SSD)-A stated she did not know if the ombudsman was notified of R53's hospital transfer. SSD-A stated she has not seen that done. SSD-A provided a list of all residents who had been transferred to the hospital since 5/1/18. The residents who were transferred to the hospital in addition to R53 included: -R82, whose Admission Record indicated R82 was admitted to the facility on 4/17/18. The transfer list indicated R82 was transferred to the	F 623	discharge from the facility. A listing of 15 residents (R53, 82, 83, 42, 75, 27, 50, 182, 183, 184, 185, 186, 187, 188, 189) who had been transferred to the hospital since 5/1/18 was immediately collected during the survey process and faxed to the Ombudsman. All residents transferred to the hospital are currently tracked daily during IDT meetings and listed for monthly notification. The facility'□s notification to Ombudsman of hospital transfers has been reviewed and updated to ensure compliance of this requirement. The facility□'s Social Services staff have been re-educated on this process. Audits of notification will be reviewed at daily IDT meeting with reviews of hospital transfers and then monthly for 2 months to ensure the notification has been sent to the Ombudsman. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process. Social Services Director/Designee will be responsible party. Completion Date: September 25th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ____ B. WING ____	C 08/16/2018

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F 623	Continued From page 20	F 623		

hospital on 5/7/18.

-R83, whose Admission Record indicated R83 was admitted to the facility on 3/6/13. The transfer list indicated R83 was transferred to the hospital on 6/12/18.

-R42, whose Admission Record indicated R42 was admitted to the facility on 6/21/18. The transfer list indicated R42 was transferred to the hospital on 6/6/18.

-R75, whose Admission Record indicated R75 was admitted to the facility on 7/24/18. The transfer list indicated R75 was transferred to the hospital on 8/10/18.

-R27, whose Admission Record indicated R27 was admitted to the facility on 9/7/17. The transfer list indicated R27 was transferred to the hospital on 8/13/18.

-R50, whose Admission Record indicated R50 was admitted to the facility on 10/11/16. The transfer list indicated R50 was transferred to the hospital on 8/14/18.

-R182, whose Admission Record indicated R182 was admitted to the facility on 7/30/18. The transfer list indicated R182 was transferred to the hospital on 8/3/18.

-R183, whose Admission Record indicated R183 was admitted to the facility on 7/25/18. The transfer list indicated R183 was transferred to the hospital on 8/1/18.

-R184, whose Admission Record indicated R184 was admitted to the facility on 5/21/18. The

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 623	Continued From page 21 transfer list indicated R184 was transferred to the hospital on 5/24/18. -R185, whose Admission Record indicated R185 was admitted to the facility on 5/8/18. The transfer list indicated R185 had been transferred to the hospital on 6/4/18. -R186, whose Admission Record indicated R186 was admitted to the facility on 3/23/18. The transfer list indicated R186 was transferred to the hospital on 6/5/18. -R187, whose Admission Record indicated R187 was admitted to the facility on 4/30/18. The transfer list indicated R187 was transferred to the hospital on 6/8/18. -R188, whose Admission Record indicated R188 was admitted to the facility on 11/12/17. The transfer list indicated R188 was transferred to the hospital on 6/30/18. -R189, whose Admission Record indicated R189 was admitted to the facility on 7/9/18. The transfer list indicated R189 was transferred to the hospital on 7/9/18. The facility was unable to provide a policy and procedure for notification of the ombudsman of hospital transfers, though provided a tool for Required Transfer and Discharge Notices dated 6/8/17. The tool directed a notice to the ombudsman would be made when practicable, and could be done monthly for all transfers to a hospital.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		9/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 625	Continued From page 22 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure written notification of the bed hold was provided to 1 of 1 residents (R53) reviewed for hospitalization. Findings include: R53's Admission Record printed 8/16/18,	F 625	All residents have the potential to be affected if the bed hold process is not explained to them upon transfer to the hospital. R53□s bed hold notification process was immediately reviewed during survey and the form signed by family who had initially given verbal acknowledgement.	

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F 625	Continued From page 23 indicated R53 was admitted to the hospital on 7/9/18. R53's medical record lacked documentation of a written bed hold notice provided to the resident or resident representative. R53's hospital Discharge Summary indicated R53 had been admitted to the hospital on 8/11/18, and discharged on 8/13/18. On 8/14/18, at 8:51 a.m. R53's resident representative verified R53 had been hospitalized on 8/11/18, and stated a written notice of the bed hold had not been provided. On 8/15/18, at 9:40 a.m. registered nurse (RN)-B stated the nurse has the resident sign the bed hold paper work before they are sent to the hospital, and then it is forwarded to the nurse manager. RN-B stated she had not seen R53's bed hold notice. On 8/16/18, at 9:23 a.m. business office manager (BOM) stated the bed hold policy is provided to the resident upon admission, and when a resident is transferred to the hospital, the nurse has the resident sign the bed hold. R53 had a bed hold form with a verbal bed hold from the resident representative. BOM stated there was no indication the bed hold form was sent to the resident or representative. On 8/16/18, at 9:34 a.m. social services director (SSD)-A stated she did not know if a written bed hold form was provided to the resident, and stated she did not think a written copy of the bed hold notice was provided to residents, but the business office would do a courtesy call the next	F 625	The facility□s bedhold and return policy was reviewed and currently intact. Facility will continue to follow the current bed-hold and return policy for all other residents transferred to the hospital. Facility staff will be re-educated on bed hold and return process to ensure residents/family equally understand the process and sign the form. Audits of bed-hold form completion will to be reviewed upon admission, daily IDT meeting with reviews of hospital transfers for 4 weeks. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process. Social Services Director/Designee will be responsible party. Completion Date: September 25th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 625	Continued From page 24 day and explain the charges. On 8/16/18, at 9:44 a.m. SSD-A stated they were sending an original copy of the bed hold notice with the resident and kept the copy at the facility. On 8/16/18, at 11:19 a.m. RN-B stated a copy of the bed hold notice for R53 had not been provided to R53 or to the resident representative. The facility policy and procedure for Bed-Hold for Hospital Transfer and Therapeutic Leave revised 12/16, directed the nurse or designated person to provide a form to acknowledge receipt of the bed hold policies and procedures for return, and if the resident representative is not present to sign the form, it would be sent out to them. The policy and procedure further directed a narrative note to be written to reflect written information of the bed-hold and return policy was received by the resident or resident representative.	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oral cares were offered with morning cares for 1 of 2 residents (R41) reviewed for oral cares. Findings include: R41's quarterly Minimum Data Set (MDS)	F 677	All residents have the potential to be affected if cares are not provided to them per their assessment and care plan. Resident R41 was assessed for completion of oral cares and cares are now being provided routinely per her care plan. Other residents will continue to be	9/25/18

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 677	Continued From page 25 completed 3/14/18, indicated R41 needed direct staff assistance with daily oral cares, and toothbrush was recommended each morning and evening with a soft toothbrush and fluoride toothpaste. R41's care plan dated 7/30/18, indicated R41 had her own teeth, and required set up of supplies and cues with oral cares twice daily. The nursing assistant (NA) care guide undated, indicated R41 needed set up and cues with oral cares, but did not indicate number of times daily. On 8/13/18, at 2:24 p.m. R41 was observed to have several missing teeth, and was picking at her teeth, which had white coating on them. On 8/15/18, R41 was continuously observed from 7:14 a.m. until 10:27 a.m. On 8/15/18, at 7:14 a.m. R41 was in her wheelchair in the dining room. R41 received breakfast at 7:36 a.m. and ate independently until 8:01 a.m. R41 continued to sit in her wheelchair at the table until 8:59 a.m. when a volunteer wheeled her to the chapel for church. R41 was pushed back to the unit at 9:58 a.m. At 10:27 a.m NA-E approached R41 to take her to the bathroom. R41 was observed for 3 hours and 13 minutes and was not offered oral cares during this time. On 8/16/18, at 9:31 a.m. registered nurse (RN)-B stated residents are to be offered oral cares in the morning and at bed time. On 8/16/18, at 10:46 a.m. nursing assistant (NA)-E stated she had not offered oral cares to	F 677	assisted with oral cares daily per their care plans. Staff have been re-educated on offering oral cares for all residents in need. Audits will be completed for 6 residents x 4 weeks for those that have been identified as requiring assistance with oral cares. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process. Director of Nursing or designee will be responsible party Completion date: September 25th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 26 R41 during morning cares, and had never seen residents offered oral cares in the morning. NA-E stated she wouldn't know how to fit in oral cares with everything else that needs to be done. NA-E also stated that she had never seen oral cares done by other NAs, even when she was orienting to the facility. NA-E stated evening NA's do more oral cares. On 8/16/18, at 10:55 a.m. NA-D stated she performs oral cares on residents during morning cares. On 8/16/18, at 1:48 p.m. the director of nursing (DON) stated she expected oral cares to be offered in the morning, at night, and after meals. A policy on oral cares was requested but not received from the facility.	F 677		
F 678 SS=K	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to initiate cardio-pulmonary resuscitation (CPR) and activate the emergency medical system (EMS) when 1 of 1 residents (R82) experienced a cardiac arrest (absence of respirations and pulse) in accordance with the resident's advance directives. This resulted in the death of R82. In addition, the facility's policies	F 678	All residents have the potential of being affected if their Code Status is not appropriately followed in the event of a CPR event. Resident R82 is deceased. All other identified 22 residents (R77, 46, 17, 78, 15, 14, 4, 50, 39, 64, 77, 49, 47, 30, 13, 12, 235, 233, 237, 52, 31, 72) with	9/25/18

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 678	Continued From page 27 and practices placed 22 of 22 residents (R76, R46, R17, R78, R15, R14, P4, R50, R39, R64, R77, R49, R47, R30, R13, R12, R235, R233, R237, R52, R31, and R72) whose advanced directives indicated full resuscitative status, at risk of potential harm or death and was an immediate jeopardy situation. The immediate jeopardy began on 7/1/18, at 5:00 a.m. when CPR was not initiated for R82 when he was found unresponsive and without pulse or respirations, and staff did not administer CPR according to his advanced directives. The administrator and director of nursing (DON) were informed of the immediate jeopardy on 8/15/18, at 5:25 p.m. The immediate jeopardy was removed on 8/16/18, at 2:50 p.m. but noncompliance remained at the lower scope and severity of a G, isolated actual harm that is not immediate jeopardy. Findings include: R82's Admission Record printed 8/15/18, indicated diagnoses that included chronic respiratory failure with hypoxia, unspecified diastolic congestive heart failure, atrial fibrillation hypertension, sleep apnea, and dependence on supplemental oxygen. R82's 5 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 6/27/18, indicated he was cognitively intact, required extensive assistance will all activities of daily living (ADLs) except walking in his room and on the unit. R82's Provider Orders for Life Sustaining Treatment (POLST) directed, "Cardiopulmonary	F 678	Full Code Status were immediately reviewed during Survey and their POLSTS and orders reviewed to ensure they reflected matching wishes. A facility process to ensure all residents Code Status wishes upon admission are reflected on their POLST was immediately put in place. Furthermore, a process to ensure any changes or updates on resident□s wishes are reflected in their POLSTS and orders was also put in place. Facility CPR policy was immediately updated to reflect current standards. Extensive education with Nursing was completed during Survey on identification of residents with Full Code status designated in their Advanced Directive and when to initiate CPR on residents. Facility medical providers have been educated on the new process of having them confirm/update any POLST updates in order form. A complete facility audit of Advanced Directives has been completed and will continue x 4 weeks with daily IDT meetings for all new admissions and scheduled care conferences. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process. DON or designee will be responsible party Completion date: September 25th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 678	Continued From page 28	F 678		

Resuscitation (CPR): Patient has no pulse and is not breathing. Attempt Resuscitation/CPR)." The POLST was signed by the R82's spouse on 6/20/18, with the indication that R82 had capacity, and by the advance practice nurse practitioner on 6/21/18.

R82's order summary report printed on 8/15/18, indicated R82 had orders that included a 6/22/18, order for use of a continuous positive airway pressure (CPAP) (used to treat sleep apnea) every evening and night shift for sleep apnea; a 6/20/18, order for oxygen by nasal cannula at 5 liters per minutes (LPM) to keep oxygen saturations at greater than 88% to 94%. The oxygen order indicated baseline supplemental oxygen at 2 LPM at rest with increase to 4-6 L with activity. R82's order summary report also indicated a 6/20/18, order for CPR with selective treatment.

A 6/21/18, progress note, indicated an initial care conference was held on 6/21/18, and R82 planned short term stay with plans to return home after physical therapy (PT) and occupational therapy (OT) were complete.

On 6/29/18, at 2:14 p.m. a progress note indicated R82 wished to transfer to another facility to be closer to home, and the facility faxed a referral.

On 6/29/18, at 10:28 p.m. a progress note indicated R82 had 2 episodes of emesis, had stated he didn't feel well, out of nowhere, and had thrown up in his sleep.

On 6/29/18, at 10:35 p.m. a progress note dated indicated R82's CPAP machine was held due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 678	Continued From page 29	F 678		

the 2 episodes of emesis.

On 7/1/18, at 2:52 a.m. a progress note indicated R82 would not wear the CPAP mask.

On 7/1/18, at 5:51 a.m. a progress note indicated, "At about 0200 [2:00 a.m.] this writer and NAR [nursing assistant registered] went in to patients room to do complete bed change d/t [due to] large incontinent void. Patient was having significant tachypnea, was anxious, and accelerated heart rate. Oxygen sats checked and were at 72% with NC [nasal cannula] in place. Oxygen was at 5 LPM [liters per minute]. This writer switched NC to oxygen mask d/t patient breathing heavily through mouth. This writer sat with patient encouraging slow breathing and to breath in through nose and out through mouth. About 0230 patient was starting to calm down and oxygen sats were at 83%. Patient was able to be roused and was responding appropriately. Patient continued having brief episodes of tachypnea, and this writer talked patient through episodes. At 0300 patient was calmed and oxygen sats had come up to 90% at the 5 LPM. When this writer left room, patient was calm and breathing was stable. NAR had looked into patients room around 0430 and patient did not appear restless. When NAR went into patients room again at 0500, patient appeared to not be breathing, oxygen mask was lying on floor by foot of bed, and covers were lying on floor next to bed. NAR alerted this writer about patient. This writer went into room at 0510 and patient had no respirations, no heart rate, was cool to the touch, and limbs were starting to get stiff. Mottling was significant on back of legs, arms, hands, and back. This writer checked patients code status which was CPR with selective treatment. Based

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 30	F 678		

on findings/condition of patient, CPR was not performed."

On 8/15/18, at 8:26 a.m. the assistant director of nursing (ADON) stated if a resident was not breathing and did not have a pulse, she would check their code status, if full code would initiate CPR, unless they, "Had that dusky appearance," extreme rigidity, blood pooled in back or are cool to touch. The ADON stated the staff had recent training in code status and when to do CPR or not do CPR.

On 8/15/18, at 11:15 a.m. the Monarch consultant nurse (CN) stated the facility had notified the state agency when they found out an LPN-E, working the night shift had not notified the physician when R82 had a change in condition and subsequently died. CN stated they looked into whether R82 should have received CPR or not and determined that he did not meet the criteria for CPR (however the facility was not following current American Heart Association guidelines for determining when CPR should not be initiated). This was after the human resource director had met with LPN-E to terminate employment and received more explanation from her. The explanation as to why CPR had not been performed was not documented.

On 8/15/18, at 11:23 a.m. the DON stated she had not been working at the facility at the time R82 had resided there.

On 8/15/18, at 11:29 a.m. registered nurse (RN)-A stated CPR should not have been started for R82. RN-A stated signs of death including rigidity of limbs, and blood pooling in a person's back are signs of death that would indicate to not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ____ B. WING ____	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 678		F 678		

Continued From page 31
start CPR.

On 8/15/18, at approximately 11:30 a.m. registered nurse consultant (RNC) stated R82 met the criteria for not starting CPR. Licensed practical nurse (LPN)-E was interviewed and stated CPR should not have been started.

On 8/15/18, at 2:38 p.m. LPN-J was interviewed and stated she would perform CPR on someone if they were listed full code, "No matter what," but it also depended on if they were cold, or had other signs of not breathing for a long time, such as stiffness.

On 8/15/18, at 2:52 p.m. RN-B was interviewed and stated she would not do CPR on someone if they had rigid joints or if they had blood pooling in their back.

On 8/15/18, at 2:14 p.m. the geriatric nurse practitioner (GNP) stated an on-call provider should have been notified of R82's declining condition. The GNP stated CPR should not be performed if a person was "Stiff" or "Cold," and indicated nursing judgement was involved, and there was a short window of effectiveness when beginning CPR. The GNP also verified R82 was listed as a full code, and CPR was not performed.

The 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care; Part 3: Ethics, included: "Criteria for not starting CPR in all OHCA (out of hospital cardiac arrest). While the general rule is to provide emergency treatment to a victim of cardiac arrest, there are a few

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 678	Continued From page 32	F 678		

exceptions where withholding CPR might be appropriate, as follows:
1. Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril.
2. Obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity [a bluish discoloration of lowest part of body], decapitation, transection, or decomposition).
3. A valid, signed, and dated advanced directive indicating that resuscitation is not desired, or a valid, signed, and dated DNAR (do not attempt resuscitation) order.

The facility's Cardiopulmonary Resuscitation Protocol revised 5/15, directed a nurse will determine the need for CPR. CPR would be initiated immediately based upon that nurse's and/or the clinical team's determination and evaluation of the resident. The protocol further directed CPR will not be initiated if death is unobserved and obvious clinical signs such as, but not limited to: no response to external stimuli, no BP [blood pressure], no palpable or audible apical pulse, no respirations, pupils dilated and fixed AND in the present of the following irreversible signs of death is present:
a. Rigor Mortis: rigidity/stiffening of the muscles and extremities.
b. Dependent Lividity: settling/pooling of the blood in a part of the body causing a purplish red discoloration of the skin.
c. Decapitation: separation of the head/skull from the body.
d. Decomposition: decaying of the body.

R76's quarterly MDS dated 7/10/18, indicated moderately impaired cognition. However, R76's annual MDS dated 10/16/17, and quarterly MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 33	F 678		

dated 4/11/18, indicated R76 had been cognitively intact prior to the recent MDS. R76's face sheet printed 8/16/18, indicated diagnoses that included chronic kidney disease, stage 3 (moderate). R76's POLST was signed but not dated by the resident. R76's POLST was signed by an RN on 4/15/14, but the physician signature was not dated. The POLST indicated R76 designated staff to attempt CPR if R76 had no pulse and was not breathing. R76 was at risk of death if s/he went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R46's quarterly MDS dated 7/2/18, indicated she was cognitively intact. R46's Face Sheet printed 8/16/18, indicated diagnoses that included chronic obstructive pulmonary disease, adult failure to thrive and type 2 diabetes. R46's POLST was signed by the resident, but not dated. R46's POLST was signed by the nurse practitioner on 3/27/18. The POLST indicated R46 designated staff to attempt CPR if R46 had no pulse and was not breathing. R46 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R17's quarterly MDS dated 5/23/18, indicated she was cognitively intact. R17's Face Sheet printed 8/16/18, indicated type 2 diabetes, congestive heart failure and vascular dementia without behavioral disturbances. R17's POLST was signed but not dated by the resident. R17's POLST was signed by the nurse practitioner on 12/22/13. The POLST indicated R17 designated staff to attempt CPR if R17 had no pulse and was not breathing. R17 was at risk of death if she went into an unwitnessed cardiac arrest and staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 34 were following their policy and practice of not performing CPR. R78's admission MDS dated 8/3/18, indicated he had severely impaired cognition. R78's Face Sheet printed on 8/16/18, indicated diagnoses of partial paralysis following a stroke. R78's POLST was signed by his daughter and Power of Attorney (POA) on 7/27/18. R78's POLST was signed by the nurse practitioner on 7/30/18. The POLST indicated R78's POA designated staff to attempt CPR if R78 had no pulse and was not breathing. R78 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR. R15's admission MDS dated 5/31/18, indicated she was cognitively intact. R15's Face Sheet, printed on 8/16/18, indicated diagnoses that included atrial fibrillation. R15's POLST was signed but not dated by the resident. R15's POLST was signed by an RN on 5/24/18, and by the nurse practitioner on 5/30/18. The POLST indicated R15 designated staff to attempt CPR if R15 had no pulse and was not breathing. R15 was at risk of death if she went into an unwitnessed cardiac arrest and staff following their policy and practice of not performing CPR. R14's admission MDS dated 5/31/18, indicated he was cognitively intact. R14's Face Sheet, printed on 8/16/18, indicated diagnoses that included spinal stenosis (narrowing of the spinal canal and compression of the spinal cord), atrial fibrillation (irregular heart rhythm). R14's POLST was signed but not dated by the resident. R14's POLST was signed by a nurse practitioner on 5/30/18. The POLST indicated R14 designated	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 678	Continued From page 35	F 678		

staff to attempt CPR if R15 had no pulse and was not breathing. R14 was at risk of death if he went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R4's significant change MDS dated 7/16/18, indicated he had severely impaired cognition. R4's Face Sheet printed on 8/16/18, indicated diagnosis of Alzheimer's Disease with early onset and frontotemporal dementia. R4's POLST was signed by his son and POA on 5/30/18. R4's POLST was signed by the nurse practitioner on 5/30/18. The POLST indicated R4's POA designated staff to attempt CPR if R4 had no pulse and was not breathing. R4 was at risk of death if he went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R50's quarterly MDS dated 7/10/18, indicated she was cognitively intact. R50's Face Sheet, printed on 8/16/18, indicated diagnoses that included chronic kidney disease and end stage renal disease. R50's POLST was signed by the resident on 10/12/13. R50's POLST was signed by a nurse practitioner on 10/13/16. The POLST indicated R50 designated staff to attempt CPR if R50 had no pulse and was not breathing. R50 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R39's significant change MDS dated 6/26/18, indicated she had moderately impaired cognition. R39's Face Sheet, printed on 8/16/18, indicated diagnoses that included Alzheimer's disease, CHF and atrial fibrillation. R39's POLST was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 678	Continued From page 36	F 678		

signed but not dated by her daughter. R39's POLST was signed by a nurse practitioner on 6/30/16. The POLST indicated R39 designated staff to attempt CPR if R39 had no pulse and was not breathing. R39 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R64's annual MDS dated 7/24/18, indicated he had severely impaired cognition. R64's Face Sheet, printed on 8/16/18, indicated diagnoses that included cerebral infarction (stroke), and vascular dementia with behavioral disturbances. R64's POLST was signed by his wife on 8/25/16. R64's POLST was signed by a nurse practitioner on 8/25/16. The POLST indicated R64 designated staff to attempt CPR if R64 had no pulse and was not breathing. R64 was at risk of death if he went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R77's admission MDS dated 8/2/18, indicated she was cognitively intact. R77's Face Sheet, printed on 8/16/18, indicated diagnoses that included fracture of the lumbar spine and pelvis. R77's POLST was signed but not dated by the resident. R77's POLST was signed by a nurse practitioner on 7/27/18. The POLST indicated R77 designated staff to attempt CPR if R77 had no pulse and was not breathing. R77 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R49's admission MDS dated 8/2/18, indicated she was cognitively intact. R49's Face Sheet, printed on 8/16/18, indicated diagnoses that

F 678 Continued From page 37 F 678

included fracture of the left tibia and left radius. R49's POLST was signed and dated by the resident on 7/11/18. R49's POLST was signed by a nurse practitioner on 7/12/18. The POLST indicated R49 designated staff to attempt CPR if R49 had no pulse and was not breathing. R49 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R47's admission MDS dated 8/2/18, indicated he was cognitively intact. R47's Face Sheet, printed on 8/16/18, indicated diagnoses that included surgical aftercare following a surgery on the nervous system. R47's POLST was signed by his wife on 6/9/18. R47's POLST was signed by a nurse practitioner on 6/11/18. The POLST indicated R47's wife designated staff to attempt CPR if R47 had no pulse and was not breathing. R47 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R30's quarterly MDS dated 6/15/18, indicated she was cognitively intact. R30's Face Sheet, printed on 8/16/18, indicated diagnoses that included lumbar fracture, spinal stenosis and left hip pain. R30's POLST was signed by the resident on 12/10/17. R30's POLST was signed by a nurse practitioner on 12/11/17. The POLST indicated R30 designated staff to attempt CPR if R30 had no pulse and was not breathing. R30 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R13's admission MDS dated 5/22/18, indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 678	Continued From page 38	F 678		

she had moderately impaired cognition. R13's Face Sheet, printed on 8/16/18, indicated diagnoses that included pneumonia, sepsis and respiratory failure. R13's POLST was signed by her daughter on 8/3/18. R13's POLST was signed by a nurse practitioner on 8/6/18. The POLST indicated R13's daughter designated staff to attempt CPR if R13 had no pulse and was not breathing. R13 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R12's quarterly MDS dated 5/20/18, indicated she was cognitively intact. R12's Face Sheet, printed on 8/16/18, indicated diagnoses that included Bell's Palsy (facial muscle weakness or paralysis) and hypertension. R12's POLST was signed but not dated by the resident. R12's POLST was signed by a nurse practitioner on 3/2/15. The POLST indicated R12 designated staff to attempt CPR if R12 had no pulse and was not breathing. R12 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R235's face sheet, printed on 8/16/18, indicated he was admitted on 7/31/18. R12's Face Sheet further indicated diagnoses that included a stroke and diabetes. R235's POLST was signed but not dated by the resident. R235's POLST was signed by a nurse practitioner on 8/1/18. The POLST indicated R235 designated staff to attempt CPR if R235 had no pulse and was not breathing. R235 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 678	Continued From page 39	F 678		

R233's admission MDS dated 2/6/18, indicated she was cognitively intact. R233's Face Sheet, printed on 8/16/18, indicated diagnoses that included encephalopathy and alcohol dependence with withdrawal. R233's POLST was signed by the resident on 8/1/18. R233's POLST was signed by a nurse practitioner on 8/8/18. The POLST indicated R233 designated staff to attempt CPR if R233 had no pulse and was not breathing. R233 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R237's Face Sheet, printed on 8/16/18, indicated she was admitted on 8/13/18. R237's Face Sheet further indicated diagnoses that included aphasia (inability to form language) following a stroke. R237's POLST was signed by the resident on 8/13/18. R237's POLST was signed by a nurse practitioner on 8/15/18. The POLST indicated R237 designated staff to attempt CPR if R237 had no pulse and was not breathing. R237 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR.

R52's quarterly MDS dated 7/11/18, indicated he had severely impaired cognition. R52's Face Sheet, printed on 8/16/18, indicated diagnoses that included dementia. R52's POLST was signed by his POA on 4/8/18. R52's POLST was signed by a nurse practitioner on 5/9/18. The POLST indicated R52's POA designated staff to attempt CPR if R52 had no pulse and was not breathing. R52 was at risk of death if he went into an unwitnessed cardiac arrest and staff were following their policy and practice of not

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 678	Continued From page 40 performing CPR. R31's quarterly MDS dated 6/16/18, indicated she was cognitively intact. R31's Face Sheet, printed on 8/16/18, indicated diagnoses that included heart failure, spinal stenosis and cervical fracture. R31's POLST was signed by the resident on 12/18/15. R13's POLST was signed by a nurse practitioner on 12/22/15. The POLST indicated R31 designated staff to attempt CPR if R31 had no pulse and was not breathing. R31 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR. R72's admission MDS dated 7/30/18, indicated she was cognitively intact. R72's Face Sheet, printed on 8/16/18, indicated diagnoses that included hypertension, muscle weakness and diabetes. R72's POLST was signed by the resident on 7/23/18. R72's POLST was signed by a nurse practitioner on 7/27/18. The POLST indicated R72 designated staff to attempt CPR if R72 had no pulse and was not breathing. R72 was at risk of death if she went into an unwitnessed cardiac arrest and staff were following their policy and practice of not performing CPR. The immediate jeopardy that began on 7/1/18, was removed on 8/16/18, at 2:50 p.m. when the facility took the following action and was verified as implemented. However, the noncompliance remained at the lower scope and severity level of	F 678		

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 678	Continued From page 41 G (isolated actual harm that is not immediate jeopardy) due to the death of R82. -updated their policy which included current standards, -trained staff, -identified residents who had full code status designated in their advanced directives, and placed measures to ensure staff could easily identify who these residents were. -provided information indicating all current licenses nurses had a current CPR certificate.	F 678		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to reduce the risk of pressure ulcer development for 1 of 4 residents (R41) reviewed for pressure ulcers. Findings include:	F 686	All residents have the potential of being affected if skin care plan and interventions are not followed as stated. Skin assessments, care plans, care sheets and interventions for R41 have been reviewed, updated and completed to ensure timely repositioning is completed. Updates have been made to R41□s care	9/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 686	Continued From page 42 R41's Admission Record printed 8/16/18, indicated diagnoses that included Alzheimer's Disease, dementia, muscle weakness, and adult failure to thrive. R41's quarterly Minimum Data Set (MDS) dated 6/25/18, indicated R41 had short and long term memory problems and required extensive assistance with bed mobility, transfers, and toileting. The MDS further identified R41 had not walked in the assessment period, was at risk of pressure ulcer development, was on a toileting program, was frequently incontinent of bladder and bowel, and was at risk of pressure ulcer development, but did not currently have a pressure ulcer. R41's Care Area Assessment (CAA) with an assessment review date of 3/27/18, indicated pressure ulcers were an area of actual problem/need for R41. The CAA indicated R41 was at risk of skin breakdown due to impaired mobility, bowel and bladder incontinence, advanced age, fragile skin and diagnoses of coronary artery disease and dementia. The CAA directed staff to assist with turning and repositioning every 2 hours and as needed, and to have a pressure relieving device in her bed and in her chair. R41's care plan last reviewed on 7/30/18, indicated R41 had the potential for skin impairment due to fragile skin, bowel and bladder incontinence, impaired mobility, and aspirin use. The care plan further directed staff to move R41 between surfaces every 2 hours, and as necessary. R41's toileting schedule was listed as upon getting up in the morning, at 9:15 a.m., 11:45 a.m., 1:30 p.m., 3:15 p.m., 6:30 p.m., 11:00	F 686	plans and interventions will be communicated to staff. Nursing will continue monitoring R41s skin weekly with weekly wound evaluation assessment. Skin assessments, care plans, monitoring and interventions for all other residents with altered skin will be reviewed and updated. Weekly random audits will be performed for 6 residents across all shifts for 4 weeks to ensure all residents with impaired skin are repositioned timely per their care plan. All skin assessments will be audited with scheduled MDS and significant changes. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process. DON and/or designee will be responsible person. Completion Date: September 25th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 686		F 686		

Continued From page 43
p.m., and as needed.

The nursing assistant (NA) care guide sheet undated, indicated R41 was to be turned and repositioned every 2-3 hours while awake, to be toileted upon get up, between 9-10 a.m., between 12:30-1:30 p.m., between 3-4:00 p.m., between 6-7:00 p.m., when going to bed, and as needed. The care guide also stated to toilet R41 after breakfast and dinner.

On 8/15/18, R41 was continuously observed from 7:14 a.m. until 10:27 a.m. R41 was in her wheelchair at the dining room table. R41 received breakfast at 7:36 a.m. and ate independently until 8:01 a.m., when she was encouraged to eat more by nursing assistant (NA)-E. R41 continued to sit in her wheelchair at the table until 8:59 a.m., when a volunteer wheeled her to the chapel for church. R41 was pushed back to the unit at 9:58 a.m. At 10:27 a.m. (3 hours and 13 minutes), NA-E approached R41 to take her to the bathroom.

On 8/15/18, at 10:35 a.m. NA-E brought R41 into the bathroom and with assistance from NA-D, used a mechanical lift to get R41 onto the toilet. R41's right inner buttock was observed to have a deep red area approximately 3 centimeters (cm) by 2 cm. Registered nurse (RN)-B confirmed R41 had blanchable redness in all areas of her buttocks with a deep red area that blanched and had faded. RN-B confirmed R41 did not have any open areas on her buttocks.

On 8/15/18, at 10:30 a.m. NA-E stated she got R41 up for the day at 6:10 a.m. NA-E stated she usually repositioned and toileted R41 at 9:00 a.m., but R41 goes to church on Wednesdays, so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 686	Continued From page 44 she doesn't get repositioned until after church. NA-E stated R41 was to be repositioned every 2-3 hours and confirmed that today R41 had not been repositioned from 6:10 a.m. until 10:30 a.m. (4 hours, 20 minutes). NA-E added it was hard to get someone to the toilet when another resident needed one-on-one eating assistance. On 8/16/18, at 9:24 a.m. RN-B stated R41 was to be offloaded every 2 to 3 hours, and the toileting program on her care guide was based on R41's own patterns. RN-B did not know why R41 hadn't been repositioned prior to going to church. RN-B also stated it was an oversight on her part that the skin and bowel and bladder sections of the care plan did not address repositioning, and that the care plan did not match the care guide used by nursing assistants. On 8/16/18, at 1:50 p.m. the director of nursing (DON) stated repositioning schedules were based on individual residents' tissue tolerance and risk for pressure ulcers, but she would generally expect repositioning every 2-3 hours, and would expect this to be in the care plan. The facility's Skin Assessment and Wound Management policy dated July 2018, lacked standards for repositioning or offloading dependent residents.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		9/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 45 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide toileting according to the care planned toileting schedule for 1 of 3 residents (R41) reviewed for bowel/bladder incontinence. Findings include:	F 690	All residents have the potential to be affected if bowel and bladder care plan is not followed as stated. R41s care plan and aide care sheets were reviewed and were up to date. All other incontinent residents care plan and aide sheets were reviewed and updated. Facility staff will be re-educated to focus	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 690	Continued From page 46 R41's Admission Record printed 8/16/18, indicated diagnoses that included Alzheimer's Disease, dementia, muscle weakness and adult failure to thrive. R41's quarterly Minimum Data Set (MDS) dated 6/25/18, indicated R41 had short and long term memory problems, and required extensive assistance with bed mobility, transfers, and toileting. The MDS further identified R41 had not walked in the assessment period, was at risk of pressure ulcer development, was on a toileting program, and was frequently incontinent of bladder and bowel. R41's Care Area Assessment (CAA) reviewed 3/27/18, indicated R41 required extensive assistance with toileting, and was incontinent of bladder and bowel. The CAA further directed staff to anticipate R41's needs, and to follow a toileting program, and the plan of care. R41's care plan reviewed on 7/30/18, directed R41's toileting schedule was listed as upon getting up in the morning, at 9:15 a.m., 11:45 a.m., 1:30 p.m., 3:15 p.m., 6:30 p.m., 11:00 p.m., and as needed. The nursing assistant (NA) care guide undated, directed R41 was to be toileted upon get up, between 9-10 a.m., between 12:30-1:30 p.m., between 3-4:00 p.m., between 6-7:00 p.m., when going to bed, and as needed. The care guide also directed to toilet after breakfast and dinner. Review of the facility's Toileting Tool from 7/1/18, to 8/15/18, (46 days) revealed 34 times when there was greater than 3 hours between toileting or check and changes for R41 during the morning	F 690	on toileting and repositioning schedules on their assignment sheets, and to reach out for support when unable to perform such tasks timely - to ensure residents receive timely care. Staff will also be educated on approach techniques when residents refuse cares. Visual and timed random audits will be performed for R41 and similar residents needing repositioning by correction date. Weekly audits of 6 residents across all shifts x 4 weeks will be completed to ensure all residents□ bowel and bladder care plan is being followed. All care plans and group sheets will continue to be audited with scheduled MDS and significant changes. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process. DON and/or designee will be responsible person. Completion Date: September 25th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 47	F 690		

or afternoon hours.

On 8/15/18, R41 was continuously observed from 7:14 a.m. unit 10:27 a.m. (3 hours and 13 minutes). At 7:14 a.m. R41 was in her wheelchair at the dining room table. R41 received breakfast at 7:36 a.m. and ate independently until 8:01 a.m. when she was encouraged to eat more by nursing assistant (NA)-E. R41 continued to sit in her wheelchair at the table until 8:59 a.m. when a volunteer wheeled her to the chapel for church. R41 was pushed back to the unit at 9:58 a.m. At 10:27 a.m. NA-E approached R41 to take her to the bathroom.

On 8/15/18, at 10:30 a.m. NA-E stated she got R41 up for the day at 6:10 a.m. NA-E stated she usually repositioned and toileted R41 at 9:00 a.m., but on Wednesdays R41 goes to church, so she doesn't get repositioned until after church. NA-E stated R41 was to be repositioned every 2-3 hours, and confirmed that today R41 had not been repositioned from 6:10 a.m. until 10:30 a.m. (4 hours, 20 minutes). NA-E added it was hard to get someone to the toilet when another resident needed one-on-one eating assistance. At 10:35 a.m. NA-E brought R41 into the bathroom, and with assistance from NA-D, used a mechanical lift to get R 41 onto the toilet. R41's brief was wet with urine.

On 8/16/18, at 9:24 a.m. registered nurse (RN)-B stated R41's toileting program on her care guide was based on R41's own patterns. RN-B did not know why R41 hadn't been toileted prior to going to church.

A policy on toileting programs was requested but not received from the facility.

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper drying and storage of food service pans to prevent potential for foodborne illness. This had the potential to affect all 75 residents residing in the facility. In addition, the facility failed to perform routine cleaning/sanitation tasks in food storage areas, food preparation areas, and the dish room to prevent foodborne illness. This had the potential to affect all 75 residents residing in the facility. In addition, the facility failed to properly cook unpasteurized eggs to reduce the risk of potential foodborne illness for 5 residents (R69, R22, R38, R4, and R46) who regularly requested over-easy, sunnyside up or poached eggs.	F 812	All residents have potential of being affected if professional standards of food service safety are not met. Parmly on the Lake is committed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. All dietary staff will be trained on Pot/Pan cleaning policy and procedure to ensure proper cleaning, drying and storage of dietary equipment. All dietary staff will be trained on how to perform routine cleaning and sanitation tasks in food storage and preparation areas. Training includes cleaning schedules, procedures for proper cleaning of specific equipment and general	9/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812

Continued From page 49

Findings include:

On 8/13/18, at 2:08 p.m. during the initial kitchen tour with cook (C)-B, three steam table pans of various sizes were observed to have been put away for future use wet. C-B verified the findings. A hardened spill on the floor of the walk-in freezer was observed, and the floor was sticky. The tilt grill was observed to have built-up grease/food debris on the top of the grill. The dry storage room floor had dried liquid spills on it. C-B verified the findings.

On 8/15/18, at 9:05 a.m. during a tour of the kitchen with the dietary manager (DM)-A the top of the dish machine was observed to have debris adhering to it. The grill, steamers, and stove were all observed to have a grease buildup adhering to their exteriors. The dish machine interior had hard water deposits built up in the water jet areas. DM-A stated the machine was supposed to be cleaned every night, but the cook "obviously didn't do it." DM-A stated the dish machine didn't appear to have been cleaned since Monday. DM-A was not sure how frequently the dish machine was de-limed. The walk-in freezer was observed to have the same frozen spill on the floor as was observed 8/13/18. DM-A stated they do not currently have cleaning schedules for the kitchen, but he and C-B visually check areas needing cleaning as they walk through the kitchen. DM-A did not know if the floor had been swept or mopped since 8/13/18. A carton of unpasteurized eggs were observed in the reach-in cooler. DM-A confirmed the eggs were used for residents who requested specially prepared eggs, such as eggs over-easy.

8/15/18,At 12:58 p.m. DM-A provided a list of five

F 812

infection control procedures.
Parmly on the Lake is committed to prevent foodborne illness for residents R69, R22, R38, R4, R46 and all other residents who request over-easy, sunny-side up or poached eggs. The facility will purchase pasteurized eggs only and staff has been trained to use only pasteurized eggs for those resident-specific orders of over-easy, sunny-side up or poached eggs.
The Registered Dietician (RD), or designee, will audit the cleaning task list completion and that equipment is clean and properly stored. The RD will audit/ensure that no unpasteurized eggs are in cold storage or on the raw food order guide history. Audits will be completed weekly x 4 weeks. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process.
Registered Dietician will be responsible person.
Completion date: September 25, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 50 residents who routinely request undercooked eggs, and have been receiving unpasteurized eggs. This list included R69 who requested eggs over easy, R22 who requested eggs sunnyside up, R38 who requested eggs over-easy, R4 who requested eggs over-easy, and R46 who requested poached eggs. On 8/14/18, at 1:53 p.m. R46 stated she had a poached egg for breakfast that morning. R46 stated she requested soft-cooked poached eggs often, and really enjoyed them with a runny yolk. R46 stated that morning not only was the yolk runny, but the white was also runny. On 8/16/18, at 8:40 a.m. R69 and R38 both had fried eggs that were hard cooked. R69 stated he liked his eggs over-easy with a runny yolk. R69 stated normally the kitchen made eggs that way for him, however, this morning the staff had told him it had to be hard cooked because of the state survey. R38 stated normally his eggs had a runny yolk, and he did not like them cooked hard like they were today. Review of the facility culinary department Infection Control Policy dated 12/16, directed fresh and pasteurized eggs were to be obtained from approved sources, and eggs will always be stored under refrigeration. The document lacked guidance on preparing non-pasteurized eggs. The policy also directed dishes that go through the dishwashing machine should air dry. Review of Cleaning Schedules policy dated 1/08, directed it was the responsibility of the Department Director to provide and post cleaning schedules. Each employee was responsible to know their assigned duty and carry it out during	F 812		

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F 812	Continued From page 51 their work shift - documenting their completed duty.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		9/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 880	Continued From page 52 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a mechanical lift was disinfected after direct contact with a resident on contact precautions (used for infections that are spread by touching the resident or items in the room) for MRSA (Methicillin-resistant Staphylococcus aureus, a	F 880	All residents and staff have the potential of being affected if proper infection control procedures are not followed during resident cares. Handwashing education has been reviewed with all staff to include utilization of equipment between residents and	

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F 880	Continued From page 53 type of staph bacteria that has become resistant to many antibiotics) in leg wounds (R45) and before brought into another residents room (R13) to be used for transfer. In addition, hand washing was not completed after working with a resident on contact precautions (R41) and prior to leaving room during two separate observations. This practice had the potential to affect all 16 residents residing on the unit. In addition, 3 insulin pens were not stored separately to prevent the cross contamination of blood borne pathogens in 1 of 5 medication carts. Findings include: R45's admission Minimum Data Set (MDS) dated 7/8/18, indicated R45 required extensive assistance to transfer and had four vascular/arterial ulcers. R45's care plan dated 7/19/18, indicated "The resident has MRSA in wounds of the lower extremities." The care plan directed staff to wear gowns and masks when changing contaminated linens, and to bag linens and close bag tightly before taking to laundry. The care plan further indicated to instruct family/visitors/caregivers to wear disposable gown and gloves during physical contact with resident. Discard in appropriate receptacle and wash hands before leaving room. Resident care equipment to be placed in room and not shared with other residents. On 8/14/18, at 1:05 p.m. R45 was observed for wound care by certified nurse practitioner (CNP)-A and the assistant director of nursing (ADON). R45 had several small open areas on both anterior and posterior bilateral legs and feet. ADON stated some areas were weeping a clear fluid.	F 880	storage of insulin pens in the Carts. Handwashing and infection control process education will continue to be provided upon hire, annually with annual reviews, skills fairs and as needed with routine audits. Handwashing audits to be completed at a minimum of 5 times per week x 4 weeks. Lift disinfecting audits to be completed 4 times per week x 4 weeks. All Medication carts will be audited once per week x 4 weeks to ensure proper storage of insulin needles. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process. DON or designee will be responsible party. Completion date: September 25th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 54	F 880		

On 8/15/18, at 7:22 a.m. R45 was observed for morning cares. Nursing assistant (NA)-A and NA-B had put on gloves and isolation gowns prior to entering room. NA-A brought a mechanical standing lift into the room which had a harness hanging over the lift. NA-A and NA-B sat R45 up on the edge of his bed, placed his feet onto the lift platform, placed the lifting harness under his arms and buckled it around his body. They then placed a strap around his legs that was attached to the lift. R45 held onto the hand grips of the lift. NA-A used the lift to stand R45, when he stood, his bare shins touched the front leg support of the lift, and his bare calves touched the leg strap. R45 was brought into the bathroom. When NA-A and NA-B had completed morning cares, they used the standing lift to assist him into his wheel chair. NA-A pushed the standing lift out into the hall, removed her gown and gloves, grabbed R45's water pitcher and left the room without disinfecting the lift or washing her hands. NA-A went to the day room, set the water pitcher next to the sink under the microwave, used her bare hands to turn on the water tap, washed her hands, removed the lid from the water pitcher and filled it with water. NA-A then returned the water pitcher to R45's room, left the room and washed her hands again in the same sink. When interviewed, NA-A stated she did not like to wash her hands in the sink in R45's room because he is on isolation. The standing lift remained in the hall outside of R45's room until 8:18 a.m., when NA-A brought the lift into R13's room, and placed it in front of R13 to use it. The surveyor stopped NA-A and asked about disinfecting the lift as it had been used for R45 who was on isolation precautions. NA-A stated she was going to disinfect it. NA-A retrieved a handful of

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	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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F 880	Continued From page 55	F 880		

Sani-wipes (a disinfectant wipe) from the nurses station, brought them back to R13's room and wiped down the mechanical lift, including areas where R45's bare legs had touched. NA-A then took a garbage bag from R13's room and placed the harness in it, tied the bag and placed it in the soiled utility room.

When interviewed on 8/15/18, at 8:44 a.m. the ADON stated R45 should have a harness for the standing lift dedicated to just him, the mechanical lift should be disinfected prior to using on any other resident, and hand washing should occur prior to leaving resident room.

During observation on 8/16/18, at 8:20 a.m. NA-E stepped out of R45's room, removed the isolation gown and gloves, stepped back in room, put the gown and gloves in a container in room, came out of room without washing hands, used the handle to open the soiled utility room door with unwashed bare hands and washed hands in that room. NA-E stated he always leaves the room to wash hands. NA-D did not know why he did not wash hands in the resident's room before leaving.

A contact precautions policy and procedure was requested, but not provided by the facility.

R41's Admission Record printed 8/16/18, indicated R41's diagnoses included dementia, history of urinary tract infections, and history of falling.

R41's quarterly Minimum Data Set (MDS) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 56	F 880		

7/6/18, indicated R41 had a moderately impaired cognitive status for decision making, required extensive assist with toilet use and transfers, and was frequently incontinent of bowel and bladder.

R41's care plan revised 1/1/18, directed staff to provide limited assistance for toilet use, and extensive assistance for transfers with a stand assist lift.

On 8/15/18, at 10:35 a.m. nursing assistant (NA)-E brought R41 into the bathroom, and along with NA-D, put the lift belt on and assisted to stand with the stand assist lift. NA-E and NA-D had donned gloves and lowered R41's brief. R41 had been incontinent of a large amount of urine. R41 was lowered to sit on the toilet. NA-D removed R41's brief, and NA-E wiped R41's perineal area after R41 had voided and was lifted to a standing position. NA-E and NA-D changed gloves but did not wash hands between the change of gloves. NA-E and NA-D lowered R41 back into her wheelchair with the stand aid assist. NA-E and NA-D removed their gloves, NA-E opened the door and propelled R41 out of the bathroom to the dining area, and NA-D removed the lift out of the bathroom. Neither NA-E nor NA-D washed their hands after removing their gloves and moving the resident in the wheelchair and the lift out of the room. NA-E washed her hands at the sink in the dining area, under the microwave where food was warmed up and served to residents.

On 8/15/18, at 10:47 a.m. NA-D verified she did not wash her hands between glove changes, after removing R41's wet incontinent brief, and should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 57	F 880		

On 8/15/18, at 10:49 a.m. NA-E verified she did not wash her hands after removing gloves, after cleansing R41.

On 8/16/18, at 10:51 a.m. registered nurse (RN)-B verified hands should be washed before and after resident cares, between glove changes and after gloves removed, and following toileting cares.

On 8/16/18, at 11:19 a.m. the director of nursing (DON) verified hands should be washed after removing gloves, and right after toileting cares.

The facility policy and procedure for Standard Precautions dated 1/08, directed staff to wash hands with soap and water after direct or indirect resident contact and body fluids, and after removing gloves. The policy further directed staff to remove gloves promptly after use, before touching non-contaminated objects and environmental surfaces, and before going to another resident and to wash hands immediately to avoid the transfer of microorganisms to other residents or environmental surfaces.

On 8/16/18, at 4:07 p.m. the North unit medication cart was observed to contain three insulin pens belonging to R9, R32, and R11 that were stored together in the same compartment or area of the cart without separation from each other. Licensed practical nurse (LPN)-C verified the insulin pens were stored together and stated that was the way it has been. LPN-C further verified all of the insulin pens were opened and were the current ones they were using.

R9's Order Summary Report printed 8/16/18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 58 indicated R9 had orders for a Basaglar Kwik Pen. R32's Order Summary Report printed 8/16/18, indicated R32 had orders for a Lantus insulin pen. R11's Order Summary Report printed 8/16/18, indicated R11 had orders for a Humulin insulin pen. On 8/16/18, at 4:36 p.m. the corporate consultant nurse stated if stored together, insulin pens should be in their own plastic bags. The facility's Storage of Medications policy revised 4/14, directed medications for individual residents were stored separately.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an odor free environment for 1 of 1 residents (R29) whose room had a strong odor of urine. Findings include: R29's Diagnosis Report printed 8/16/18, included diagnoses of Alzheimer's disease, dementia, delusional disorder and arthritis. R29's quarterly Minimum Data Set (MDS) dated 6/26/18, indicated R29 had short and long term	F 921	All residents have the potential to be affected if not provided a clean environment. All carpet areas of concern are being addressed to continue to remove any odor and maintain them in the best possible condition. Staff randomly audited have verbalized that the odor had decreased. Nursing will continue working with resident to attempt offering daily showers to minimize body odor per her care plan. Staff will be re-educated on ensuring a clean and well-maintained environment.	9/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 921	Continued From page 59 memory problems, and had some difficulty in new situations with decision making. The MDS identified R29 was independent with transfers and ambulation, and needed set up assistance with toilet use. The MDS indicated R29 was not on a toileting program, and was always continent of urine. R29's care plan revised on 5/17/18, indicated R29 had occasional bladder incontinence. The care plan directed staff were to offer assistance with toileting and peri care in the morning when R29 got up however, R29 typically declined. The care plan further indicated R29 preferred to toilet herself, and did not allow staff to assist. Staff were to observe for safety. From 8/13/18, at 7:02 p.m. through 8/16/18, at 9:10 a.m. the following urine odors were observed: On 8/13/18, at 07:02 p.m. R29's private room had a strong urine odor. The urine odor permeated into the hallway. On 8/14/18, at 1:58 p.m. a urine odor was evident from approximately 10 feet down the hall from R29's room. On 8/14/18, at 2:43 p.m. R29's room continued to have a strong urine odor. The floor was wet between the bed and the bathroom. R29 came walking down the hall to her room, and R29 also smelled of urine. On 8/14/18, at 2:49 p.m. R29 was ambulating with the walker in the day room. R29 continued to have a strong urine odor.	F 921	Audits of facility carpet cleanliness and odor to be completed weekly x 4 weeks. Audits will be reviewed by the QAPI committee to ensure completion and/or continuation of monitoring process. Maintenance Director or designee will be responsible party. Completion Date: September 25th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 60	F 921		

On 8/15/18, at 9:26 a.m. R29's room appeared to have been recently cleaned. R29's room and bathroom continued to have a strong urine odor.

On 8/16/18, at 9:10 a.m. R29's room and bathroom continued to have a definite urine odor. The smell of urine was noticeable when approaching R29's doorway. R29 was in the room sitting on the edge of her bed. A commode was over the toilet.

On 8/16/18, at 9:41 a.m. the environmental services director (ESD) verified the urine odor in R29's room and bathroom. The ESD cleaning R29's room was ongoing. The ESD stated R29 did not like people in her room so housekeeping try to get the room cleaned when R29 was out of the room. The EDS stated R29's room was cleaned when staff noticed a urine odor, and they changed any soiled lined as needed. The EDS stated they have tried cleaning with vinegar, but had not tried deodorizers or air purifiers.

On 8/16/18, at 10:13 a.m. registered nurse (RN)-B stated the nursing assistant (NA) care sheet instructed staff to offer a shower daily in morning and afternoon. RN-B further stated R29 had Alzheimer's disease, and housekeeping cleaned R29's room daily when she was out of her room.

On 8/16/18, at 10:32 a.m. R29's family member (FM)-B was interviewed via telephone. FM-B stated she was aware of the urine smell in R29's room, and staff had done everything possible to get R29 to use the toilet appropriately as R29 stood over the toilet to urinate. FM-B stated R29 also urinated in her shoes causing her shoes to smell like urine. FM-B further stated if R29 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 61 aware of the urine smell it would bother her, and R29 would be embarrassed if visitors came and the room or R29 smelled of urine. The facility's Infection Control-Housekeeping and Environmental Department policy dated 1/08, indicated the purpose was to maintain a clean and aesthetic environment and control odors.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______________	**08/16/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey The Margaret Parmley Residence was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______________	**08/16/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Margaret Parmley Residence is a 1-story building with a no basement. The building was constructed in 1972, construction Type II(111) with an addition, in 1999, construction Type II(111). In 2007 a 2-story building with no basement was added that was determined to be of Type II(111) construction. The upper floor has 12 resident rooms, and the lower level has a pool and therapy functions. There are Two assisted living buildings that are connected to the building that are properly fire separated. The facility was inspected as one building.	K 000		

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/16/2018**

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K 000	Continued From page 2 The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 101 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 133 SS=F	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that 1of 2 - two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 8.2.1.3 and 19.1.3.4. These deficient conditions could	K 133	The smoke barrier penetration above the Martha's house door was sealed the same day it was discovered, 08/16/2018. All other 2-hour fire separations have been inspected and proper sealing of	10/8/18

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____________	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 133	Continued From page 3 allow the products of combustion to travel from one building to another, which could negatively affect 20 of 101 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 08/16/2018, observations revealed that there is a penetrations that was found around a bundle wires passing through above the Martha's house door that leads to the assisted listing. This deficient condition was verified by a Maintenance Supervisor.	K 133	penetrations completed when/if required. Date completed was 08/17/2018. The Maintenance Director, and/or designee, will ensure that all penetrations are properly sealed by inspecting these areas whenever facility staff or contracted services performs work that may penetrate any 2-hour fire separation. Completion date: October 8, 2018	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not complete the annual fire door inspections in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition. This deficient practice could affect 101 of 101 residents, as well as an undetermined number of staff, and visitors	K 211	The facility ensures the means of egress is continuously maintained free of all obstructions to full use in case of emergency. A facility-wide fire door inspection was completed on 08/29/2018. The Maintenance Director has a system to track and store recurring fire door inspections. The Maintenance Director,	10/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/16/2018**

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K 211	Continued From page 4 if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 08/16/2018, during a records review and an interview with the Maintenance Supervisor, the facility did not completed the fire door inspection or inspection documentation for all of the fire rated doors located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 211	or designee, will ensure the annual inspections are completed in a timely manner and in accordance with the requirements of NFPA 101 “The Life Safely Code” and the NFPA 80 Standards for Fire Doors and other Protective Openings. Completion date: October 8, 2018	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 72 National Fire Alarm Code 2010 edition. This deficient practice could affect 101 of 101 residents, as well as an undetermined number of staff, and visitors to the facility.	K 345	Parmly on the Lake is committed to providing a safe environment or all residents which includes the testing and maintenance of the fire alarm system in accordance to current standards. A thorough smoke detector sensitivity test was conducted on 08/29/2018 which included a detailed account of all fire alarm devices that were tested and the	10/8/18

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**08/16/2018**

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K 345	Continued From page 5 Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 08/16/2018, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with a maintenance staff member revealed the following deficienct conditions: 1. That at the time of the inspection the facility's fire alarm test documentation did not contain a detailed account of all fire alarm devices that were tested and the results of the individual tests. 2. That the smoke detector sensitivity testing is out of date the last test was preformed in March 2016. This deficient condition was verified by a Maintenance Supervisor.	K 345	results of the individual tests. The Maintenance Director has a system to track and store recurring testing and maintenance of the fire alarm system. The facility Maintenance Director, or designee, is responsible to ensure the testing and maintenance of alarm systems is done in accordance with requirements. Completion date: October 8, 2018	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that	K 363		10/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/16/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 6 do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition section 19.3.6.3.13. This deficient practice could affect 20 of 101 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 08/16/2018, observations revealed that at the	K 363	Resident room door 167 has been adjusted so that it now latches in the frame properly. All other resident room doors leading to corridors have been inspected and repaired/adjusted as needed on 08/29/2018. The facility maintenance director, or designee, is responsible to ensure all resident room doors close and latch properly. Completion date: October 8, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/16/2018**

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K 363	Continued From page 7 time of the inspection the door to resident room 167 did not latch in the frame. This deficient condition was verified by a Maintenance Supervisor.	K 363		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90A(12) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 101 of 101 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 08/16/2018, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and confirmed by	K 521	Parmly on the Lake is committed to providing a safe environment or all residents which includes the testing, inspection and maintenance of the facilities fire and smoke dampers. A facility-wide inspection, cleaning and repair of all fire and smoke dampers was completed on 09/12/2018. The Maintenance Director has a system to track and store recurring fire and smoke damper testing and maintenance to ensure timely completion. The facility Maintenance Director, or designee, is responsible to ensure that the fire and smoke damper testing occurs once every 4 years. Completion date: October 8, 2018	10/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**08/16/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 521	Continued From page 8 an interview with the Maintenance Supervisor, that the facility could not provide any current testing documentation verifying that the fire and smoke dampers has been tested or inspected within the last 4 years. This deficient condition was verified by a Maintenance Supervisor.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 101 of 101 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 712	Parmly on the Lake is committed to providing a safe environment for all residents which includes conducting fire drills in accordance with NFPA 101 “The Life Safety Code” 2012 edition. The facility is current with all required drills. The facility will schedule, conduct and record fire drills at least quarterly on all shifts. The Maintenance Director has a system to track, schedule and record facility fire drills to ensure timely completion. The facility Maintenance Director, or designee,	10/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/16/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 9 On facility tour between 11:30 a.m. to 3:30 p.m. on 08/16/2018, during the review of all available fire drill documentation and interview with a maintenance supervisor that the facility did not conduct a fire drill for the overnight shift in the 2 calendar quarter the following deficient conditions were found: This deficient condition was verified by a Maintenance Supervisor.	K 712	is responsible for the overall compliance. Completion date: October 8, 2018	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to	K 918		10/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 10 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections, 9.1.3 and NFPA 110 "Standard for Emergency and Standby Power Systems 6-4, 6-4.1, and 6-4.2.2. This deficient practice could affect the safety of 101 of 101 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 08/16/2018, during the review of all available emergency generator maintenance documentation and an interview with the Maintenance Supervisor it was revealed that the facility did not have a letter of reliable service for their natural gas fuel supply from the fuel company. This deficient condition was verified by a Maintenance Supervisor.	K 918	Parmly on the Lake will ensure and maintain an emergency and standby power system in accordance with the emergency preparedness plan. This includes assuring natural gas service reliability for the facility emergency generator operation. Parmly on the Lake has obtained a letter of natural gas service reliability from Xcel Energy dated August 27, 2018 which states the very low probability of gas interruption. Completion date: October 8, 2018	
K 923	Gas Equipment - Cylinder and Container Storag	K 923		10/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/16/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 923 SS=F	Continued From page 11 CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/16/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 section 5.1.3.. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect 20 of 101 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 08/16/2018, observations revealed that in the oxygen storage room located in the TCU had the following deficient conditions: 1) the only sign found on identifying the oxygen storage room did not contain any notation stating "Medical Gases - NO smoking or Open Flame. 2) the door to the oxygen storage room did not have any fire rated label located on it. The labels appeared to have been removed at some time. 3) the oxygen storage room had a mechanical ventilation system but it was inoperable at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 923	We are committed to the safety and well-being of all residents, staff and visitors to the facility including maintaining an oxygen storage room in accordance with NFPA 99 Standards for Health Care Facilities. On 08/23/2018 a sign stating "Medical Gases – No Smoking or Open Flame" was affixed to the oxygen storage room door. The Administrator and Maintenance Director are working with suppliers to replace the oxygen room door with one that has the proper fire rating identification attached. The ventilation system motor switch was replaced on 08/22/2018 and the oxygen storage room has continuous ventilation as required. The facility Maintenance Director, or designee, is responsible to ensure oxygen storage room compliance. Completion date: October 8, 2018	

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

October 8, 2018

Randy Snyder, Executive Director
Board of Nursing Home Administrators
Park Plaza Building
2829 University Avenue Southeast, Suite 440
Minneapolis, Minnesota 55414

Dear Mr. Snyder:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the Board of Nursing Home Administrators whenever we determine that substandard quality of care has been provided to residents. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of Parmly On The Lake LLC 28210 Old Towne Road, Chisago City, MN 55013, which was completed on August 16, 2018, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

F0678 -- S/S: K -- 483.24(a)(3) -- Cardio-Pulmonary Resuscitation (cpr)

Quality of Life (§483.15). Regulations in this area grant residents the right to receive care in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The administrator is Mr. Jay Andress, .

If you have any questions, please feel free to contact me.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

October 8, 2018

Shirley Brekken, Executive Director
Board of Nursing
Park Plaza Building
2829 University Avenue Southeast, Suite 500
Minneapolis, Minnesota 55414

Dear Ms. Brekken:

This is relative to a full survey conducted at Parmly On The Lake LLC, 28210 Old Towne Road, Chisago City, MN 55013 and completed on August 16, 2018.

At the time of this survey it was determined that the residents in this facility have received substandard quality of care.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The director of nursing at the time of the survey was Christina Weiden.

If you have any questions on this matter, please do not hesitate to call me.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

October 8, 2018

Dr. Yasser Chebli
3400 W 66th Street Suite 290
Minneapolis, MN 55435

Dear Dr. Yasser Chebli:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of Parmly On The Lake LLC, 28210 Old Towne Road, Chisago City, MN 55013, which was completed on August 16, 2018, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

F0678 -- S/S: K -- 483.24(a)(3) -- Cardio-Pulmonary Resuscitation (cpr)

Quality of Life (§483.15). Regulations in this area grant residents the right to receive care in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

The above facility has prepared a plan to correct the deficiencies which we found during the survey. You can assist by discussing the survey findings with the facility's medical director. Copies of the survey findings which provide detailed information on the violations can be reviewed at the facility or at the address below.

If you have any questions, please feel free to contact me.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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